Kim Richan, MSW
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206-708-4622

License #LW60363402

Disclosure Statement

This information is given in compliance with a Washington State regulation requirement. I am a Washington State Licensed Clinical Social Worker and my license number is LW60363402.
My education includes a Master's degree in Social Work from the University of Washington. The goal of my work is to help people in emotional distress gain relief from their distress through short and long-term psychotherapy.

My clinical practice is based on psychodynamic theory, which promotes the idea that in therapy, emotional relief comes from increasing insight, perspective, and awareness generated by discussions between therapist and patient during the therapy hour. I welcome your questions about the benefits and risks of treatment as well as alternative therapies you may also find useful.

Please confirm by initialing here _______ that you are aware I am available to discuss the benefits and risks of treatment as well as the availability of alternative therapies.

My work with patients complies with all regulations as set forth by the state of Washington in RCW 18.19. If you wish to review the professional record for social workers or other allied mental health professionals, you may do so at the Department of Health website, www.doh.wa.gov.

Payment: My fee is $185 per 45-minute session for work with individuals. Fees for collaboration with other professionals, court-related activity, and inpatient psychotherapy are billed at a rate of $350 per hour.. A sliding fee scale is sometimes available for patients with limited incomes.

I do not work directly with insurance companies but many policies will reimburse your work with me under an "out-of-network" benefit. I cannot, however, guarantee reimbursement and I recommend contacting your insurance provider to verify coverage of counseling services from an "out-of- network" provider.

Payment is due at the beginning of each session.

Confidentiality:
I have provided you with a copy of my Notice of Privacy Practices, which describes how I may use and disclose your health information. In this document I want to highlight for you some of those disclosures: (1) to report suspected abuse of a child, developmentally disabled person, or a dependent adult; (2) to prevent potential, imminent harm to yourself; (3) to prevent imminent harm to another; and (4) when required by court order or other compulsory process. Disclosures may also be made if you sign a written authorization permitting disclosure.

Please refer to my Notice of Privacy Practices and Client Rights for other detailed information.

Appointment and Cancellation Policy:
Once we settle into a regularly scheduled appointment time, I reserve that time for you**.** Five (5) weeks per year are waived from charge for appointments cancelled with at least 24 hours notice. After 5 weeks of missed appointments, you will be charged for missed sessions No-show appointments and appointments cancelled after the 24-hour window are charged the full session rate, without exception. Phone calls, texts and emails are appropriate ways to convey an appointment cancellation. Whenever possible, I will confirm that I received your notice of cancellation.

Inclement Weather: The 24-hour cancellation policy applies even in the event of inclement weather. If inclement weather is forecast, it is your responsibility to cancel your appointment. Whenever possible, I will offer times during which you may reschedule your appointment.
____________ Please confirm your understanding of this cancellation policy by initialing here.

Record Keeping Policy
In accordance with Washington State law, I keep a record of our work together. The notes I keep about our sessions are limited, so as to preserve your privacy to the best of my ability.

____________ Please confirm your understanding of this records policy by initialing here.

Electronic Communications: I prefer using text and email only to arrange or modify appointments. If you choose to communicate information via email or text message that could identify you as a patient, please be aware you are consenting to the associated privacy risks. Email and texts are not a secure medium, and I cannot guarantee that information transmitted will remain confidential.

_________Please confirm your understanding of this communications policy by initialing here.

My signature below acknowledges that I have read, understood and received a copy of this Disclosure Statement and the Notice of Privacy Practices and Client Rights.

____ ____________________
Client Signature (or personal representative) Date

This form will be retained in your medical record.